NC DMA Request for Prior Approval

Recipient Information **DMA372-118**

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (✓)
1			
2			
3			
4			
5			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting Provider #:_____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____

9. Address: _____ 10. Nine Digit Zip Code: _____

11. Billing Provider # (if different from requesting):_____NPI: ☐ Atypical: ☐ 12. Taxonomy: _____

13. Address: _____ 14. Nine Digit Zip Code: _____

15. Rendering Provider # (if different from billing):_____NPI: ☐ Atypical: ☐ 16. Taxonomy: _____

17. Address: _____ 18. Nine Digit Zip Code: _____

Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Service Information

19. Procedure Code:_____ 20. Modifier(s): 1____2____3____4____ 21. Place of Service:_____

22. Description of Service to be Performed: _____

_____

_____

_____

_____

23. Requested Units:_____ 24. Unit Type:_____ _____ 25. Retroactive Request? ☐

26. Requested Begin Date: _____ 27. Requested End Date:_____

28. Requested Frequency:_____ 29. Frequency Period:_____

30. Requested Duration:_____ 31. Duration type:_____

Additional Information

(Include any additional information related to this request)

Requesting Provider's Signature:_____ Date:_____

Fax this form to CSC at: (855) 710-1964

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp